Report Summary version

This report was commissioned by Prof. John Morrison, Consultant Obstetrician and Gynaecologist, Clinical Director for the Women & Children's MCAN, HSE West North West Region (formerly Saolta) following a spike in the number of babies with neonatal encephalopathy requiring Therapeutic hypothermia (TH) born in Hospital 1.

These cases had been identified as a result of the risk management process put in place by the hospital group, and escalated appropriately to the HSE clinical risk system. There have been local preliminary assessment reviews (PAR) and national Obstetric Events Support Team (OEST) reviews of the cases concerned which were available to the review team.

Five cases of neonatal encephalopathy requiring TH had occurred in a relatively short period of time making the incidence of cooling approximately 1 in 200. The incidence would be expected to be of the order of 1 in 1000 deliveries (1.2/1000 in 2020 Aggregate Data report 2016-2020 HSE). It is worth noting that this cluster of cases and higher incidence relating to this period of time, is significantly higher than in the preceding two years.

The review team consisted of a Consultant Obstetrician and Gynaecologist, Prof. Sam Coulter-Smith who chaired the review group, a Consultant Neonatologist, Dr Pamela O'Connor, and a recently retired Director of Midwifery, Ms Marie Corbett. The review team were supported by Ms Eimear Burke Quality and Safety Coordinator, HSE West North West.

The review team had an opportunity to meet the parents of the affected infants in two of the cases and received written communication from two sets of parents. One set of parents initially declined the invitation to engage with the review process, but did engage late in the process, and submitted a written account of their care.

The reviews followed the HSE Incident Management Framework (2020) and were cognisant of the rights of all involved to privacy and confidentiality, dignity, respect, due process and natural and constitutional justice.

The review team would like to acknowledge the cooperation of all those who took part in the reviews, especially the parents who provided valuable insights in their care.

For the sake of clarity, the review team divided this summary document into the main themes arising from the review process and the facts presented. Although this review concentrated on the issues identified locally, many of these issues could and should be examined at a national level.

Infrastructure

Hospital 1 has a small maternity unit delivering approximately 1400 women annually, the caesarean section rate is 42% and the induction of labour rate is 18%. With Caesarean section rates and induction rates rising nationally, and locally, there are capacity issues for the system in dealing with this level of activity. The number of planned interventions and emergency interventions is increasing which puts additional strain on the existing infrastructure and staff.

The review team was assured that efforts are being made to provide additional theatre space for emergency caesarean sections, but there appears to be no definite time lines around this development.

It is the opinion of the review team that the location of the new obstetric emergency theatre should be on the same floor level as the labour ward, to facilitate prompt and timely access. In addition, the Special care baby unit (SCBU) should also be located on the same level as the labour ward.

Given that several of the cases reviewed, required either planned or emergency access to theatre in a timely manner, it is imperative this capacity issue is addressed immediately.

A further limitation in infrastructure was identified in that the labour ward is used as an assessment area for patients over 20 weeks, but not in labour. This can be an issue when the labour ward is busy and staffing levels are reduced, particularly at night. The review team recommends that a maternal and/or fetal assessment unit be developed to address this issue.

Communication

The review team identified communication within Hospital 1 as an issue which also needs to be addressed. The ISBAR communication tool is not always effectively used and there were cases identified where communication between members of the on call team was suboptimal, causing delay in the provision of emergency care.

There is a hospital wide emergency bleep system used to call members of the obstetric, paediatric and anaesthetic teams in the case of an obstetric emergency e.g. Category 1 Caesarean section. There is also a local buzzer system in the maternity ward area, if the buzzer system is activated, staff in the immediate area will be made aware of an emergency but not the nature or reason for the call. If the buzzer system is used inappropriately, for example, a Category 1 LSCS, then the anaesthetic and paediatric teams will not be aware of the situation.

The review team strongly recommends that the communication system is simplified and made more efficient, reducing the clinical risks associated with having two systems in place.

The mobile phone coverage in the area around the hospital does not appear to be consistently functional, and there have been situations where the staff were unable to contact the appropriate consultant on call, when assistance or advice was required. This is not a safe or satisfactory arrangement and needs to be resolved as a matter of urgency.

There were a number of situations where communication with parents was excellent and was acknowledged by the parents, but there were several instances where it could have been much better.

Where a patient comes from an ethnic minority community or where the patient's first language is not English, there are often issues with accessing clinical services easily and in a timely manner and these patients are always over represented in perinatal morbidity and mortality statistics (MBRRACE UK, Saving Lives, Improving Mothers' Care 2024).

If patients or their family have difficulty communicating their situation by phone, there should be easy access to interpreter services, if this is not practical, nor available, the patient should be requested to present themselves to the hospital for assessment of their concerns.
This issue was highlighted by one of the patients in her submission.

Given the increasing number of patients from different countries who now access maternity services, it is incumbent on maternity units to understand and put in place solutions to address the additional clinical risk posed by these patients. This will require ongoing education and training.

When patients are being followed up in the hospital after an adverse event or significant clinical incident, it is not acceptable to have patients wait for long periods of time to be seen by a clinician who is not aware of the circumstances of the case. They must be seen in a timely manner by senior clinicians who are familiar with the circumstances of the incident.
This issue was raised by one of the patients and caused her unnecessary distress.

There was one case where earlier communication between the ambulance crew and the on call obstetric team would have led to a faster transfer of the patient to theatre and better preparedness of all the staff required to respond to the situation.

In relation to communication and information given to parents when their babies were being transferred to another hospital, there were variable accounts of their experience. This is a difficult and distressing time for parents and several staff did go the extra mile to provide information and support.

One of the couples we met suggested that an information pack be available to parents whose babies are transferred to another hospital for TH treatment, to include directions, parking,

options for accommodation, and what to expect at the receiving hospital. This is something which could be easily developed and rolled out nationally.

Clinical care, Leadership and Clinical governance.

Hospital 1 has five consultant Obstetricians and Gynaecologists but relies heavily on locum consultants for out of hours on call clinical cover. There has been and continues to be long term sick leave in the consultant cohort. Further, by agreement with management, consultants' conditions differ, such as not covering nights, posts being part time and rest days entitlements that apply.

There is inequity in the on call commitments of the consultants.

The reliance on locum cover is not sustainable and is detrimental to the quality of service provided to patients and to the training of junior staff, and is frustrating for the midwifery staff. In addition, it is adversely affecting the hospital's ability to provide safe and effective care and to drive quality improvements in the service.

Again the reliance on locum consultants has meant that the hospital has suffered from lack of senior clinical leadership. There needs to be equity of on call cover from consultants. The review team identified the need for improved handover, particularly at night, between on call colleagues and better supervision of trainees.

Consultants often cover several areas of the service at the same time e.g. clinics and labour ward. There are some but not enough dedicated labour ward sessions.

Hospital 1 holds after action reviews, but not in all cases. These reviews should happen more consistently and be attended by all staff, where possible. The review team recommends that there should be an appropriate number of staff trained to do timely after action reviews. In addition, there should be better attendance of medical staff at clinical drills and skills sessions.

Several of the cases reviewed, required emergency access to theatre in the quickest possible time. The review team identified situations where there was delayed recognition of an abnormal CTG tracing and evidence of placental abruption, this delay in recognition of the severity of the situation, led to delays in getting the patient to theatre for delivery.

In addition, the review team found evidence of a staged movement of patients to the emergency theatre. There were situations where the patient was moved to the labour ward first for additional monitoring or IV access before moving to the emergency theatre for delivery. This staged movement of patients delayed delivery of the compromised baby.
In any new development, having the emergency theatre adjacent to the labour ward would make this process more efficient and safer.

The review team recommends that all category 1 caesarean sections be audited to accurately record the Decision to Delivery interval (DDI) and to identify areas where this critical time interval can be reduced wherever possible. This quality improvement measure should be monitored by the hospital and reported to the group clinical director on an ongoing basis.

The review team acknowledges that since these incidents occurred, additional drills and skills sessions have been put in place, but they are not always attended by the full medical teams, and the drills do not incorporate the 2222 emergency bleep. Emergency drills should utilise the emergency bleep to ensure all appropriate staff are in attendance. In addition, Clinical skill coordinators should be available to support staff in all areas of acute care. The review team recognise that there are weekly neonatal resuscitation drills organised by the paediatric consultants.

The review team acknowledge that the neonatal care for the five cases reviewed met the appropriate standard of care overall. In individual cases, some specific areas for improvement were identified.

The review team acknowledge that SCBU nursing staff and Midwifery team leaders are now trained as NRP (neonatal resuscitation Program) instructors, this is a very positive development.

In the smaller maternity units of which there are 11 in the country, the general paediatricians provide the neonatal care, this includes the resuscitation and stabilization of the critically ill newborn infant prior to transport for tertiary care.

In such units, the consultants and trainees have infrequent clinical exposure to maintain their skills in the management of very premature, and ill newborn infants, other than simulation and resuscitation drills and skills. It is challenging for paediatric doctors, to provide the best quality neonatal care, without sufficient clinical exposure on a regular basis. Maintenance of skills to provide advanced neonatal resuscitation for the acutely ill newborn infant requires appropriate

resources, including regular training by an onsite clinical skills facilitator and appropriate level of staffing at nursing and medical level, which is not always available due to recruitment challenges.

These issues were highlighted in our conversation with the paediatric team in Hospital 1.

The review team strongly recommends that this issue and these concerns should be reviewed at a national level.

Governance

A previous review of maternity care at Hospital 1 took place in 2018 (Walker report 2018), its recommendations were significant. Concerns around governance, training and consultant presence were highlighted, reliance on locum consultants, communication and timely recognition of deteriorating clinical situations were also noted.

Unfortunately although changes were made following the 2018 review, many of the same scenarios have been identified by this 2024 review process.

One of the recommendations in the 2018 Report was to improve clinical governance. One of the measures taken in this regard was the giving of responsibility for maternity services to a new Clinical Director (CD) from the hospital group. While this may have seemed a positive move, it is important to highlight that the holder of this office has no executive authority within Hospital 1, has no regulatory or budgetary control, their role is purely oversight and advisory.

As time evolved, an Associate clinical director (ACD) role was created, the role was initially provided on a part time basis by a Consultant based in Hospital 2. The role now remains part time and is filled by a consultant based in Hospital 1. The ACD has a direct reporting relationship with the hospital manager and also a clinical reporting relationship with the CD based in Hospital 2. Clinical and Operational governance across the group is therefore complex, in that the ACD still has no executive power. If the ACD raises issues of clinical concerns with the CD, the ACD is required to approach any request for enhancement in service through the General Manager and their line management structure within the HSE.

The review group question the efficiency achieved in this complex structure of operational and clinical governance of Hospital 1. There have been a number of changes in recent years to the governance structures of HSE hospitals from Health Boards to Hospital groups to regional

groups. The further the distance between the key decision makers and the clinical coalface, the more likely it is that decisions will be significantly delayed and based more on financial merit than clinical need.

It is the opinion of the review team that clinicians must take up clinicians must take up stronger leadership roles and responsibilities. For this to happen there must be a reduced reliance on locum consultants. One way of achieving this is to create joint consultant posts in senior clinical roles across the group as has happened in other regions.

Overview

The Walker 2018 report on delivery of maternity services at Hospital 1, identified significant clinical concerns and although measures were put in place to deal with these issues, many of the same issues have been identified in this 2024 review of 5 cases.

Hospital 1 delivers only 1400 babies annually. A unit of this size cannot provide the full range of maternity and newborn services. It is clear that units of this size find it difficult to attract permanent members of medical staff and rely heavily on locum consultants.

It is operationally challenging and there are significant clinical risks in providing maternity services in this way. In addition, it is difficult to continue to provide a service which meets the expectations of parents in a modern society, in units with such small numbers of deliveries. It is not possible to train midwives and doctors to an acceptable level of competence with such little on call clinical exposure.

From its experience in conducting this review the Review Team considers that the issues which are the subject matter of this report are ones which, by virtue of their nature, are ones that could plausibly arise in other similar sized maternity units. As such, the review team strongly recommends that there is an opportunity to review the way maternity services are delivered across the country.

If obstetric care is to be provided in a hospital, then the full range of support services should be available, provided by staff with the appropriate skill set and training to allow them to keep up their own clinical skills and to train junior doctors, nursing and midwifery staff.

It is disappointing that the clinical issues identified previously in 2018 have recurred. Unless the issues and concerns identified in this report are addressed with long term sustainable

solutions, there is a high risk that these or similar issues will re occur. It will be important that someone is identified to take responsibility to ensure the necessary changes are made and continuously monitored.

The review team recognises that some of the required changes will require positive engagement at a political level. However, the current situation does not meet the expectations of parents, increases clinical risk, and is no longer sustainable.

It is important to acknowledge that despite the issues and limitations identified in this review process, there is a cohort of staff delivering care in Hospital 1 who have been making considerable efforts to provide the best quality service they can within these limitations.

Signed

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Ms Marie Corbett
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References

1. MBRRACE UK, Saving Lives, Improving Mothers' Care 2024.
2. Neonatal Therapeutic Hypothermia in Ireland Annual Report 2020.
3. Communication (Clinical Handover) in Maternity Services National Clinical Guideline No. 5.